

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

668-044110

6085

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002

Registrar's No.

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

BY AFFIDAVIT OF H. OWENS, MEDICAL CERTIFICATION

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Kansas City	
Length of stay in 1b 40 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS (If outside, give location) 619 West 12th. St.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLIFFORD NOEL McKey		4. DATE OF DEATH Month 11 Day 6 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-10-16
9. AGE (last birthday) 47		IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Truck Lines	
11. BIRTHPLACE (City and state or country) Waynoka, Oklahoma		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Wallace McKey		13b. MOTHER'S MAIDEN NAME Beatrice or Bernice Lyons	
14. NAME OF HUSBAND OR WIFE Shirley McKey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 2	
16. SOCIAL SECURITY NO. 619 West 12th. Street		17. INFORMANT Mrs. Shirley, 619 West 12th. Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G I Bleeding DUE TO (b) Cirrhosis of Liver DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7:30 a.m. p.m. Month, Day, Year 11-6-63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION 11-6-63	
20g. COUNTY 11-6-63		20h. STATE 11-6-63	
21. I attended the deceased from 11-6-63 to 11-6-63 and last saw him alive on 11-6-63 Death occurred at 7:30 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE M.D. Coroner	
22b. ADDRESS 152 Union Station-K.C., Mo.		22c. DATE SIGNED 11-8-63	
23a. NAME OF CEMETERY OR CREMATORY National Cemetery		23b. LOCATION (City, town, or county) (State) Fort Leavenworth, Kansas	
24. FUNERAL DIRECTOR WEILERT FUNERAL HOMES(S) K.C., MO.		25. DATE RECD. BY LOCAL REG. 11-8-63	
26. REGISTRAR'S SIGNATURE Bessie Smith			

(Licensed Embalmer's Statement on Reverse Side)

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

_____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack E. Moore

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Licensed Embalmer No. 4729

P. O. Address Trimble, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.